

Enrollment Fee Allotment Authorization

Please type or print all entri	es.				
Sponsor Name: Last		First	M.I.	Spon	sor SSN or DBN
Home Address: Street	Apt. No.	City	State	ZIP Code	•
	below the action mark one of the four	_			
for TRICARE Prime® er	y allotment to UnitedHea prollment fees for the TR e your allotment is set up	ICARE West Region			
Discover®) for the three-m	ent (personal check, cashio nonth payment of TRICARE ed when transferring from	Prime enrollment fee	s payable to Unitedl	Healthcare Military	& Veterans. I understand
Please charge my card f	or the three-month paym	ent. Card type (chec	k one): 🔲 Visa®	□ MasterCa	ard [®] Discover [®]
Card Number			Exp	_ / Verifica	ation Code
Card Billing Address		City	State 2	Today's l	Date
Please Change my e	xisting monthly allotment		re effective (MM/Y	Y)/_	from:
Please Stop my existi	ng allotment to UnitedHe	ealthcare effective (MM/YY)/	·	
I hereby authorize this re until I request in writing the this allotment at a future transferring my enrollme	nat it be changed or s date if I become dise	topped. As a cou enrolled from the	rtesy to me, I au	thorize United	Healthcare to stop
Sponsor Signature (Rec	quired):			Da	ate:
InitedHealthcare will attempe e notified by UnitedHealthcould not be started by this loast Guard, or U.S. Public elated Compensation) are i	are to make alternative date. Allotments are on Health Service. Other p	e payment arrange only authorized from	ments if the allotn military retireme	nent from your nt pay received	military retirement pay I from either: DFAS,
If completing thi	s authorization as part of	f your Enrollment Fo	orm, please include	e with the Enroll	ment Form.
Please complete, sign, a authorization and payme	and mail this _{Eı} ent to:	RICARE West Reg nrollment Departm P.O. Box 105492 tlanta, GA 30348-5	ent O	r fax to:	1-877-890-7297